JUST FOR KIDS
PEDIATRIC DENTISTRY & ORTHODONTICS

7170 Indiana Avenue
Riverside, CA 92504
(951) 248

www.JFKPEDORIVERSIDE.com

WELCOME

NEW PATIENT MEDICAL AND DENTAL HISTORY

CHILD'S INFORMATION

Child's Name: _____ Nickname: _____
Date of Birth: _____ Sex: _____
Address: _____ City: _____ State: ___ Zip: _____
School: _____ Grade: _____ Hobbies/Interests _____
Whom may we thank for referring you to our practice: _____

PARENTS' INFORMATION

Parents' Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Single

Parent 1 Name: _____ Birthdate: _____
Address: _____ City: _____ State: ___ Zip: _____
Home Number _____ Work Number _____ Cell Number _____
Employer: _____ Occupation: _____
Email: _____
Preferred contact method: ☐ Email ☐ Text ☐ Call ☐ Mail

Parent 2 Name: _____ Birthdate: _____
Address: _____ City: _____ State: ___ Zip: _____
Home Number _____ Work Number _____ Cell Number _____
Employer: _____ Occupation: _____
Email: _____
Preferred contact method: ☐ Email ☐ Text ☐ Call ☐ Mail

DENTAL INSURANCE INFORMATION

Primary Insured Name:_____ SSN: _____ DOB: _____
Ins. Company Name: _____ Group Policy No: _____ Ph. # _____
Secondary Insured Name: _____ SSN: _____ DOB: _____
Ins. Company Name: _____ Group Policy No: _____ Ph. # _____

CHILD'S MEDICAL HISTORY

Child's Physician: _____ Date of last visit: _____ Reason for visit: _____
Name of Practice: _____ Phone #: _____
Are Immunizations Current? ☐ Yes ☐ No
Is your child under medical care at present? ☐ Yes ☐ No If Yes, please explain: _____

Has Your Child had any of the following diseases or conditions? Please check off ALL that apply:

☐ ADD/ADHD	☐ CHRONIC SINUS INFECTIONS	☐ HEART DISEASE	☐ RHEUMATIC FEVER
☐ ALLERGIES	☐ CHRONIC EAR INFECTIONS	☐ HEART MURMUR	☐ SICKLE-CELL DIS/TRAIT
☐ ANEMIA	☐ CYSTIC FIBROSIS	☐ HEART DEFECTS	☐ TUBERCULOSIS
☐ ANXIETY/DEPRESSION	☐ SEIZURES/EPILEPSY	☐ HEMOPHILIA	☐ NEUROLOGICAL PROBLEMS
☐ ASTHMA	☐ DEVELOPMENTAL DELAY	☐ KIDNEY PROBLEMS	☐ ORTHOPEDIC PROBLEMS
☐ AUTISM SPECTRUM	☐ DIABETES	☐ LIVER PROBLEMS	☐ EYE PROBLEMS
☐ BLEEDING DISORDER	☐ DOWN SYNDROME	☐ LUNG PROBLEMS	☐ ACID REFLUX
☐ CANCER	☐ HIV/AIDS	☐ PSYCHIATRIC TREATMENT	☐ EMOTIONAL DISTURBANCES
☐ CEREBRAL PALSY	☐ HEPATITIS	☐ SPEECH/HEARING PROBLEMS	☐ ORAL/SENSORY INTEGRATION
☐ CLEFT LIP/PALATE	☐ MENTAL RETARDATION	☐ BIRTH DEFECTS	
☐ HIGH BLOOD PRESSURE	☐ LEARNING DISABILITY	☐ PREMATURE BIRTH	

Does your child have any other diseases, conditions or syndromes not listed above? ☐ Yes ☐ No
If Yes, please explain: _____
Is your child allergic to any food or medicine? ☐ Yes ☐ No If Yes, please list: _____

CHILD'S MEDICAL HISTORY *(Continued)*

Is your child currently taking any medications? ☐ Yes ☐ No If Yes, please list: _____

Has your child ever been sedated or had General Anesthesia? ☐ Yes ☐ No If Yes, what for? _____

Has your child ever had surgery or been hospitalized? ☐ Yes ☐ No If Yes, please explain: _____

Is your child having any difficulties in school? ☐ Yes ☐ No If Yes, please explain: _____

Is there anything else we should know about your child? ☐ Yes ☐ No If Yes, please explain: _____

Is there anything about your child you would like to discuss in private? ☐ Yes ☐ No

DENTAL HISTORY

Reasons for today's dental visit (check all that apply):

☐ FIRST EXAMINATION ☐ ROUTINE CHECK-UP ☐ TOOTHACHE OR SWELLING ☐ CAVITIES
☐ APPEARANCE OF TEETH ☐ CROWDING ☐ ACCIDENT/INJURY

Other: _____

Has your child been to a dentist previously? ☐ Yes ☐ No When: _____ Where: _____
Were X-Rays taken: ☐ Yes ☐ No ☐ Not sure If Yes, may we contact them to get copies? ☐ Yes ☐ No

Does your child have any of the following habits?

☐ THUMB/FINGER SUCKING ☐ MOUTH BREATHING ☐ PACIFIER ☐ SNORING
☐ LIP SUCKING/BITING ☐ GRINDING/CLENCHING ☐ BOTTLE/SIPPY CUP TO SLEEP

What source of water does your child drink? ☐ City Water ☐ Bottled Water ☐ Well Water
Is your child breast fed or using a bottle/sippy cup? ☐ Yes ☐ No If No, what age did it stop? _____
Child's typical eating pattern: ☐ 2-3 meals/day ☐ eats throughout the day
Frequency of tooth brushing? ___ times per day, flossing? ___ times per day
Who does the brushing? ☐ Child ☐ Parent/Guardian ☐ Both
What type of toothpaste does your child use? ☐ Fluoride ☐ No Fluoride ☐ No Paste

How would you describe your child's temperament? (Check ALL that apply)

☐ OUTGOING ☐ SHY ☐ STUBBORN ☐ ANXIOUS ☐ FRIGHTENED ☐ REGULAR KID
☐ CURIOUS ☐ MOODY ☐ FRIENDLY ☐ DEFIANT ☐ ACTIVE ☐ COOPERATIVE

Has your child ever experienced any problems or complications due to dental care? ☐ Yes ☐ No
If Yes, please explain: _____

CONSENT

The information I have given is correct to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in my child's medical status and insurance benefits. I authorize Just For Kids Pediatric Dentistry to complete **a Dental Evaluation, including Examination, X-Rays, Photographs, Cleaning and Fluoride Treatment** when necessary as standard of care to properly diagnose and record any and all dental conditions. I authorize my insurance company to pay Just For Kids all insurance benefits otherwise payable to me for services rendered. I also authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges for services rendered whether or not it is covered by my insurance, including all late payment service charges. This consent is to remain in effect from the date indicated until cancelled in writing.

Authorized signature _____ Relationship to Child _____ Date _____

OFFICE USE ONLY

SBE Prophylaxis required: ☐ Yes ☐ No Precautions: _____
Summary: _____
Caries Risk Assessment: ☐ Low ☐ Med ☐ Hi

Dr signature _____ Date _____

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Dr. Rick J. Nichols, DDS

Informed Consent for Behavior Management Techniques and Acknowledgement of Receipt of Information

Health professionals have an obligation to provide their patients with information regarding the treatment and procedures they are recommending. "Informed Consent" indicates your awareness of sufficient information to allow you to make an informed personal choice concerning your child's dental treatment, after considering the risks, benefits, and treatment alternatives.

Please read this form carefully and ask questions about anything you do not understand. We are eager to explain things further, if needed.

It is our goal that all care delivered in this office be of the highest quality possible. The children should not only have their dental needs met, but the treatment must be completed in such a manner so that the children do not become traumatized during the process. We believe very strongly that every child should have a positive dental experience for a lifetime. Sometimes completing treatment is difficult or even impossible due to a child's lack of cooperation. Behavior may be influenced be a number of circumstances, including but not limited to; history of a previously traumatic experience, lack of maturity, developmental or behavioral abnormalities, physical disabilities, and stubbornness. Disruptive behaviors may include; kicking, hitting, screaming, grabbing the dentist's hands or sharp instruments, turning their head, or unwillingness to open their mouth.

Every effort will be made to obtain cooperative behavior by using warmth, love, kindness, friendliness, persuasion, gentleness, and understanding. However, occasions may arise where additional behavior management techniques may be required to eliminate or reduce disruptive behavior and to prevent the child from injuring themselves or our staff. The following is a list of the most commonly utilized techniques found in pediatric dental office, including ours.

1. **Tell-Show-Do:** The dentist or staff educates and prepares the child for the procedure by telling them what is going to happen next, showing them (usually on their fingernails) and completing the procedure just like he/she said. This is very helpful to alleviate fear of the unexpected or unknown.

2. **Positive Reinforcement:** The staff attempts to always reward good behavior with positive affirmations in the form of verbal praise or material rewards (toys and stickers).

3. **Voice Control:** The staff may raise and lower the volume and tone of their voice to both discourage disruptive behavior and acknowledge good cooperation. Much care is taken as to not make the child feel threatened. It is not the content of the discussion that is important, but the manner in which it is communicated.

4. **Solo Communications with the Child:** Those individuals who accompany the children to their dental visit are asked to be passive observers, unless the dentist or staff elicit their involvement in the conversation. This is important so that the child can clearly hear the commands from the dentist and or staff. If too many individuals are speaking to the child at once, the child may become confused or frustrated.

(Additional Information on Back)

5. **Mouth Props:** These are devices which may be placed into the child's mouth to prevent them from closing at inappropriate times, which may result in them injuring themselves or compromising treatment.

6. **Physical restraint by Dentist, Staff, and /or Parents:** On occasion, it is required that some restraint be used in order to prevent the child from injuring themselves or others. This may involve gently holding the child's hands, stabilizing the head, and/or controlling leg movement.

7. **Nitrous Oxide Sedation:** This technique is indicated for children who may be mildly or moderately anxious. It is not intended to put children to sleep, but only relax them, in order to minimize their anxiety. There is no known risk to children from this technique, and the effects are eliminated within 5 minutes of breathing 100% oxygen or room air.

8. **General Anesthesia:** There are a number of situations, which require the use of this technique. Children who suffer from generalized severe dental decay, "Baby Bottle Tooth Decay", moderate to severe developmental disabilities, or have a recent history of a traumatic experience resulting in severe dental phobia or anxiety, may be unable to cooperate, thus, predisposing themselves to additional traumatic experiences. In order to adequately treat these individuals, we have chosen to utilize the services of a Dental Anesthesiologist to complete these procedures on an outpatient basis in the office. These appointments are scheduled in advance with full parental consent in advance.

Verbal consent will be obtained from a parent/guardian prior to the use of any of these techniques. Other techniques may be available at other offices. If you are interested in those, please ask us about them.

Acknowledge of Receipt of Information

The listed **Behavior Management Techniques** has been explained to me. Alternative techniques, at my request, have also been explained to me, as have the advantages and disadvantages of each technique, including the option of not completing the necessary dental treatment. The philosophy of the **Behavior Management Techniques** utilized in this office has been explained to me.
I hereby authorize and direct Dr. Rick J. Nichols, D.D.S., and his staff to utilize these **Behavior Management Techniques** listed on this form to assist in the provision as to complete the necessary dental treatment for _____, my child, or legal ward. There are no other exceptions, unless so stated here (if none, write "None") _____.

I hereby acknowledge that I have read and understand this consent, and that I had an opportunity to have all my questions, in regards to the previously stated techniques, answered in a satisfactory manner, and I further understand that I have the right to be provided with answers to questions which may arise during the course of my child's dental treatment.

I further understand that this consent will remain in effect, unless terminated by me in writing.

Date:_____

Relationship to Child: _____

Parent/Legal Guardian Signature: _____

Parent/Legal Guardian Printed: _____

I hereby acknowledge that myself, or a member of my staff has explained the use of the **Behavior Management Techniques** to the Parent/Legal Guardian prior to obtaining their consent.

Dentist's Signature: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect February 1, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed a the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Parent Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree we may do so.

Persons involved in Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information we will provide you with an opportunity to object to such uses or disclosures in the event of your incapacity or emergency circumstances we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (Such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.25 for each page, $35.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure).

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 4, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information (Your request must be in writing and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If we receive this Notice on our Website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may Submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Privacy Officer

Telephone: (909) 798-0604

Address: 104 East Olive Avenue, Suite 200, Redlands, CA 92373

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this offices Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgment

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

_____

_____

_____

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Dental Treatment and Financial Responsibility

A *Treatment Plan* will be prepared for you, detailing your child's specific dental needs as well as the related estimated costs of that treatment. *Just for Kids Pediatric Dentistry* is a fee for service dental office, and payment or insurance co-payments are due as services are rendered. We are sensitive to the fact that some patients may require alternative payment options, and therefore, we accept the following:

1) **Cash, Debit Card**
2) **Visa, MasterCard or Discover**
3) **Care Credit –** Monthly Payment Plan (this is a separate line of credit, with no annual fee and does not affect the balance of other credit cards).

Regarding Dental Insurance

There are many types of dental insurance. Some of them are considered great to work with and allow the dentist to decide which treatment options are best for your child. Others are very difficult to deal with, and ask the dentist to make compromises in his care, thus preventing the dentist from providing the highest quality of dental care for your child. This office is not willing to allow insurance companies to influence our standard of care, so there are insurances that we are willing to bill for our patients and there are others we will not. If you have dental insurance, whether it is one we will bill or one we will not, our team is able to help you optimize your insurance benefits. We ask that you pay any deductible and estimated patient portion for all covered and non-covered services as they are rendered. Please utilize one of the payment options listed above.

Please be aware that we are only able to estimate what your insurance coverage may be, and that the actual patient portion may be more than expected. The responsible party is still responsible for the entire amount. All balances, which remain over 45 days, are subject to a 1.5% monthly finance charge and a $25.00 late payment fee, if the balance is not paid in full within 10 days of the statement date.

Appointments

Appointment times are reserved especially for you. If you must change your appointment time, we ask that you please notify us immediately. If a pattern of late cancellations or no-shows develops, you may be subject to a $25.00 fee for each missed appointment.

_____ _____

Signature of Responsible Party/Parent Date

JUST FOR KIDS
PEDIATRIC DENTISTRY & ORTHODONTICS

FINANCIAL RESPONSIBILITY AGREEMENT

I voluntarily and knowingly request and consent to the services, treatments and/or procedures recommended by the dentist and to all diagnostic methods deemed appropriate by the dentist which may include, but not be limited to, x-rays, study models, imagery, and other aids. I authorize the dentist to perform all such services, treatments and/or procedures and to utilize all such diagnostic methods. Further, I acknowledge and understand that the dentist may engage the assistance of others in performing such services, treatments and/or procedures and in utilizing such diagnostic methods.

I understand that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the services, treatments, procedures and/or diagnostic methods that have been recommended. I also understand that the use of anaesthesia carries with it significant risk that have ben explained to me.

I understand and acknowledge that I am fully and completely responsible for the payment of all costs associated with the services, treatments, procedures and/or diagnostic methods performed and utilized by the dentist and others. I acknowledge that any insurance coverage or managed care benefit that I may have is based on a contract between my insurance company or managed care company and me, my spouse and/or my employer. The dentist is not a party to this contract and the services, treatments, procedures and/or diagnostic methods are provided to me. Therefore I acknowledge that I am fully responsible for the payment of all sums owed to the dentist for the services, treatments procedures and/or diagnostic methods provided to me. As a courtesy to me, the dental office will bill my insurance company or managed care company for any reason (including but not limited to the insurance company or managed care company declining coverage after initially approving it) or if the insurance company or managed care company fails for any reason to reimburse the dentist within 30 days after being billed by the dentist. I acknowledge that it is my responsibility to provide the dentist with my current insurance or managed care information and any changes thereto.

All returned checks will be subject to a $50 returned check fee. Any account balances that remain unpaid for 90 days from the date of service shall accrue interest at the rate of 19 percent (19%) per year and may be referred to a collection company or attorney. In the event this occurs, I understand that I will be liable for collection costs of $250. Further, in the event any unpaid account balance is referred to an attorney for collection, I agree also to be responsible for all costs and reasonable attorney's fees incurred in connection therewith.

I consent to the dentist's use and disclosure of my health information to my insurance company or managed care company and any agent thereof. I hereby assign to the dentist all of the insurance and managed care benefits due to me for the services, treatments, procedures and/or diagnostic methods provided to me and I authorize my insurance company and/or managed care company to make a payment directly to the dentist for the costs associated therewith.

I further consent to be contacted by the dentist, any agent of the dental office, or any collection agency (or agent thereof) or attorney to whom an unpaid account balance has been assigned or referred by mail at any address that I provide to the dental office and/or by facsimile, email or phone number (whether a cell phone or land line) that I provide to the dental office or any agent of the dental office.

Parent/Guardian:_____ Date:_____

Print Name:_____

Patient Name:_____